Maryland Insurance Administration
Responses to Request for Comment
February 21, 2006

Request for Comments – Consumer Complaints:

MIA should brief the committees on the challenges it is facing in resolving life and health non-medical necessity complaints in a timely fashion and the steps it is taking to improve performance on this measure.

Response: The objective for this unit prior to FY2007 had been to resolve 75% of complaints within 90 days of receipt of the complaint. The percentage actually resolved in this timeframe during years FY 2003, 2004, and 2005 averaged a little over 90%. As a result the standard for FY2007 was increased to resolving 85% within 90 days.

In May, 2005 one of the Complaint Investigators in this unit retired. A Hiring Freeze Exception Request form was completed for this vacancy. However, it was at this time that the agency had to relinquish positions because of a state-wide workforce reduction, and this was one of the PINs that was abolished. The loss of this PIN has resulted in a 20% increase in the workload of the remaining investigators.

The decrease from 90% to 75% in the estimated number of complaints resolved within 90 days is the result of the two factors noted above. The one factor of the loss of the PIN is compounded by the other factor which is the increase from 75% to 85% in the number of complaints to be resolved within 90 days.

The most direct way to resolve complaints as expeditiously as possible would be to move an existing position within the MIA to the Complaints unit but that would serve to seriously hamper the unit giving up the PIN, resulting in simply the shifting of the problem within the Agency. One area that shows promise in expediting the handling of complaints is through the increased use of technology and, in particular, the filing of complaints through a web-based system. However, that is viewed as more long-term and will not address this issue in the short-term.

Request for Comments – SPDAP:

The executive director should brief the committees on the progress of implementing the SPDAP.

Response: MHIP conducted a statewide educational and enrollment campaign in the fall of 2005 to assist 35,000 Senior Prescription Drug Program (SPDP) members with their transition to Medicare Part D. This consisted of numerous mailings (including a guidebook summarizing all of the nearly 70 Medicare Rx options in Maryland), a dedicated toll free call center and over 70 workshop events, where an estimated 10,000 members were given individual counseling and online assistance to determine which of

the Part D options covered their drugs at the lowest cost. This campaign was a tremendous success, with 22,000 or two-thirds of SPDP members individually enrolling in a Part D plan of their own choosing, and thus not being randomly auto-assigned by the state. No other state was able to accomplish this level of informed, voluntary selection and enrollment. The remaining 9,000 SPDP members, were randomly auto-assigned among all 18 stand-alone prescription drug plan sponsors ("PDP"s) in January, for coverage effective February 1st.

Foreseeing the benefit delivery problems under the new Medicare Rx coverage, the MHIP Board sought and the General Assembly and Governor granted authority last year to extend the SPDP program through January 2006. January's initial claims data indicates that many members took advantage of this extension.

Since November 2005, MHIP has been in contract negotiations with the 21 PDPs chosen by Medicare for Maryland. These contracts formalize the process by which SPDAP will coordinate with the PDPs to provide the premium subsidy to SPDAP members. The contract also requires a commitment from the PDPs to implement SPDAP's benefit subsidy once emergency legislation, currently being considered by the General Assembly under SB 283 and HB 702, is enacted. MHIP has experienced difficulty getting some of the Medicare Rx plans to contract at all, even though all plans have acknowledged that they must accept the state's premium subsidy. While MHIP has appealed to CMS to assist in this process, the outcome of negotiations with some PDPs remains unclear.

One option, being sought through amendments to MHIP's proposed emergency bill, is for the SPDAP to issue its own separate benefit card, with an estimated annual value of up to $200, that would be used to separately provide the state's benefit subsidy in conjunction with SPDAP members' Medicare Rx benefit card. Under this approach, Maryland's subsidy would be coordinated at the pharmacy through a point of sale coordination process defined by CMS guidelines. While a separate card is not the most efficient manner for Maryland to coordinate with Part D, it may be necessary due to the current administrative capacity of the new Medicare program and some of its participating plans.

Request for Comments – MHIP:

The MHIP executive director should inform the committees on what, if any, actions should be taken to reduce the fund balance and the minimum fund balance that should be maintained as a reserve.

Response: As stated in the analysis, MHIP's fund balance should not be viewed as an excess or surplus, since MHIP is a stand-alone insurance plan that is separate from the state general fund. It cannot under state law draw or borrow from the general fund, and must maintain a certain level of reserves against unanticipated losses. MHIP's role as an insurance plan for those with chronic conditions must also be considered, since unlike other health plans, it must have reserves to address new applicants with expensive conditions, such as transplant recipients and hemophiliacs.

The Board formally voted in January 2006 that MHIP's fund balance should remain with the plan. Plan enrollment has grown by 55 percent in the past year, and in January a new record was set for monthly applications. New applicant interest should continue in response to a radio and print campaign starting later this month, and a targeted application form to be supplied to hospitals and physicians which focuses on MHIP's 60 qualifiying medical and behavioral health conditions. MHIP's per capita claims cost has also risen dramatically in the past year, as the plan's caseload has shifted from former SAAC members (many of whom would not have been eligible for MHIP) to new enrollees who entered the plan by meeting its medical eligibility criteria. MHIP's new income subsidy program, MHIP+, started only 3 months ago and will also be a source of significant enrollment growth, requiring a higher level of hospital subsidy expenditures to fund discounted premiums and copayments for moderate and low income members. In addition, the enactment last year of HB 627, which allocated $15 million in MHIP resources to fund a new Medicaid eligibility system, also required the system to include an MHIP referral component for those denied Medicaid eligibility. The premium discounts under MHIP+ provide those denied Medicaid a viable second health coverage option, and should form a new pool of applicants for MHIP.

Our independent actuary has advised that three months of claim payments should be set aside as a strategic claims reserve. Using FY07 projected claims expenditures, approximately $35 million in reserves would be necessary to support the projected enrollment. Based on MHIP's projected growth, any significant reduction in MHIP's fund balance by legislative action could necessitate consideration by the Board of steps to curb program costs, such as a premium increase, a lower cap on MHIP+ enrollment, or reinstatement of the 6 month pre-existing condition exclusion.

Request for Comments – MHIP:

The MHIP executive director should brief the committees on the steps it has taken to resolve the issues raised by the market conduct examination and the legislative audit and what actions are still needed and the timeline for accomplishing those actions to fully address these issues.

Response: In November 2004, 16 months after the launch of Maryland Health Insurance Plan, the Maryland Insurance Administration (MIA) initiated a market conduct examination of the MHIP and its plan administrator. Simultaneously, a routine legislative audit of MIA and MHIP was initiated.

MHIP acknowledges that the plan had operational challenges and service shortcomings in its initial months of operation, not the least of which was a rapid implementation, which MIA testified in 2002 could not be accomplished in the time required in MHIP's authorizing legislation. During its initial two and a half years, MHIP has implemented a number of plan enhancements in serving over 14,000 individuals, including:

- a new federal tax purchasing credit to reduce the cost of health coverage among dislocated workers and retirees from Bethlehem Steel and other companies. Maryland was a national leader in the implementation and enrollment of the federal tax credit.

- one of the first combined medical and prescription drug deductible plans available in Maryland, allowing members to be eligible for federal tax advantaged health savings accounts.
- a subsidized premium and benefit plan, called MHIP+, for moderate and low income uninsurable individuals.
- expansion of MHIP's network to 24,000 providers.

The above accomplishments have been accompanied by certain service and compliance deficiencies. Most of the findings and problems identified in the market conduct examination and legislative audit were already being addressed by MHIP through Board approved actions initiated prior to the MIA examination. The following summarizes major findings and steps completed or under implementation by MHIP:

Exam Finding – *Documents reviewed by examiners failed to provide sufficient evidence of adherence and oversight of contractor performance guarantees.*

MHIP Response - During the summer of 2004 (the start of MIA's exam period), MHIP experienced a sudden 50 to 100 percent increase in call volume, and a 200 to 300 percent increase in applications. This sudden spike was attributable to the enactment of HB 669 (signed in May 2004) which made MHIP the only option for individuals with federal guaranteed-issue rights under HIPAA, and the Board's decision to lift the plan's pre-existing condition exclusion. This increased demand impacted MHIP service levels during the MIA examination period. In response the Board initiated a corrective action plan in November 2004, which included the plan administrator hiring additional and higher quality customer service staff. Since February 2005, MHIP's contract administrator phone and application service levels have met or exceeded MHIP contract requirements.

Exam & Audit Finding – *Materials reviewed by the examiners and auditors failed to document and support any financial reimbursement by MHIP to its third party administrator.*

Since its inception, MHIP staff have verified premium income and medical expenses against other information recorded by its contract administrator, including monthly cash financial statements showing premium income and medical expenses. Administrator cash activity statements have been periodically reviewed against the contractor's bank statements. Since April 2005, plan premium collections have been routinely reconciled against the administrator's bank statements, and starting in September 2005 monthly paid claim totals have been reconciled against individual provider check payment records. MHIP has also been subject to two independent financial audits in 2004 and 2005, which included an independent review of MHIP and its contractor's MHIP financial statements, income and expenditure details, and a summary review of sample claims. In April 2005, MHIP's contractor refunded the plan for $48,000 in improper interest charges.

To improve state oversight of claims performance using MHIP's limited staff resources, the Board authorized a state claims data analysis system, the contract for which was signed in April 2005. The data system is currently under acceptance testing and, once implemented, will enable MHIP staff to more effectively monitor claims and financial activities of the plan administrator.

Exam & Audit Finding – *Numerous instances of claims processed beyond 30 days, duplicate claims, interest payment on late claims, failure to pay a clean claim.*

The most pervasive claim processing issues cited in the MIA exam are from the initial problems with MHIP's behavioral health benefit. In August 2004 MHIP initiated discussions with its administrator to change its behavioral health subcontractor due to member complaints and problems, especially related to claims with non-network providers. In July 2005 MHIP's administrator engaged a new behavioral health subcontractor, the result of which has been improved and more prompt claim payments, with no member complaints on behavioral health claim processing. MHIP's administrator has also modified its quality assurance screenings in order to expedite all claims payments, and has taken steps to either reduce or properly code claim denials. Regarding the duplicate claims cited in the legislative audit, those claim examiners responsible for the 8 duplicate claims identified, out of 67,000 total claims processed, have been given further training. The following illustrates the history of MHIP claim payment performance:

Measure	July – Dec 2003	Jan – June 2004	July – Dec 2004	Jan – June 2005	July – Nov 2005
Clean claims adjudicated within 30 days	84.5%	92%	88.7%	90.5%	93% * all medical claims, unaudited

To improve state oversight of claims performance using MHIP's limited staff resources, the Board authorized a state claims data analysis system, the contract for which was signed in April 2005. The data system is currently under acceptance testing and once implemented will enable MHIP staff to more effectively monitor overall plan claims processing. MHIP will also request that MIA market conduct staff perform a follow-up review of claim denials in order to assess improvement by the plan administrator.

Exam Finding - *Based on violations, MHIP is not effectively monitoring the Plan for compliance with Maryland grievance, coverage and adverse decision law.*

In January 2005, MHIP's administrator created a dedicated grievance and appeals unit to improve its handling of member coverage, grievance and adverse decision issues. Since then, monthly complaints filed with the MIA have dropped, while timely and sufficient administrator responses to filed complaints has improved.

Audit Finding – *Accountability and control over assessment and premium tax revenue was not adequate.*

MHIP is working with the State Treasurer to establish a properly named bank account. Assessment revenues have been reconciled to the Comptroller's records.

Audit Finding – *MHIP reported inaccurate plan financial data to the legislature.*

Updated financial information has been provided to the legislative staff.

Request for Comment – Rate Stabilization Fund:

MIA should update the committees on the operation of the Rate Stabilization Fund and the likelihood that the planned appropriation schedule will allow payments of subsidies as needed.

Response: The initial allocation of $52 million to the Rate Stabilization Account in fiscal year 2006 to pay calendar year 2005 subsidies will prove to be more than is needed. The MIA estimates that approximately $35 million of the fiscal year 2006 allocation will be needed for calendar year 2005 subsidies.

Due a change in the methodology in the law for computing the subsidy factor for calendar year 2006 through 2008, the entire amount allocated to the rate stabilization account for fiscal years 2007 through 2009 should be expended.

The only circumstance under which the allocation could be exceeded would be if the medical professional liability insurance market covered by carriers participating in the subsidy program were to expand. While at this point we don't anticipate this happening, the law does provide that if the balance of the rate stabilization account insufficient to pay health care provider subsidies, the carrier shall reduce the subsidy paid to each health care provider electing to receive a subsidy.

Based on our projections at this point in time we believe that the premium tax revenues from HMOs and MCOs will be sufficient to meet the allocation schedule contained in the law for both the rate stabilization account and the medical assistance program account. See attached projections.

PROJECTED REVENUES, ALLOCATIONS AND UNALLOCATED BALANCE
(in millions)

		ALLOCATIONS			
Fiscal Year	Revenues	Rate Stabilization Account	Medical Assistance Program	Maryland Insurance Administration	Unallocated
2005	$27.00	$0.00	$3.50	$0.35	$23.15
2006	$80.00	$52.00	$30.00	$0.35	$(2.35)
2007	$88.00	$45.00	$45.00	$0.35	$(2.35)
2008	$97.00	$35.00	$65.00	$0.35	$(3.35)
2009	$107.00	$25.00	all remaining revenue	$0.35	$0.00
Projected Unallocated Balance June 30, 2009					**$15.10**

Health Care Rate Stabilization Fund
Financial Snapshot
April 1, 2005 to December 31, 2005

Receipts (April 1, 2005 to December 31, 2005):	
Premium taxes	$ 62,550,539
Premium tax exemption value *	8,289,945
Interest income	19,556
Total receipts	$ 70,860,040
Disbursements (April 1, 2005 to December 31, 2005):	
Payments to medical professional liability insurers	29,551,535
Payments to Department of Health and Mental Hygiene	11,789,945
Total disbursements	$ 41,341,480
Excess of receipts over disbursements	$ 29,518,560
Fund balance (cash basis), April 1	-
Fund balance (cash basis), December 31	$ 29,518,560

Maryland Insurance Administration
Responses to Recommendations
February 21, 2006

Recommendation #1: Increase turnover to better reflect historical levels. Over the past three years, the Maryland Insurance Administration's (MIA's) vacancy rate has averaged 6.1% and as of January 1, 2006, the rate was 4.88%. This reduction increases the turnover rate to 3% which will still allow MIA to fill 5.4 additional positions.

Total Special Fund Reductions: $170,000

Response: The Administration accepts the recommendation.

Maryland Insurance Administration
Responses to Request for Comment
February 22, 2006

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February 22, 2006

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Total Special Fund Reductions: $170,000

Response: The Administration accepts the recommendation.